

TESTIMONY  
BEFORE THE JOINT COMMITTEE ON FINANCE  
BY THE WISCONSIN CHAPTER OF NASW  
APRIL 1999

While social workers across the state work in a number of areas affected by budget changes, I would like to highlight three areas of concern for our chapter: long term care redesign, W-2, and child abuse and neglect prevention. Along with today's testimony, I have attached the NASW-WI position statements prepared by the Legislative and Social Policy Committee for our recent lobby day.

Family Care

NASW supports the development of Family Care through pilot projects. However, we oppose the proposed management of Family Care. NASW supports public administration of Family Care through the Counties. Also, the counties should have more than two years to establish their long term care programs before bids from private agencies are requested to operate the Family Care program. Finally, the NASW supports an increase in funds for the Community Options Program (COP) for the counties not in the pilot program so that they may prepare the way for the development of Family Care in these counties.

Child Abuse and Neglect Prevention

Despite the recommendations of the 1997 Joint Legislative Council Committee on Prevention, the Governor has not included funds in his budget to extend the Prevention of Child Abuse and Neglect (POCAN) program for this biennium. In addition to the expansion of POCAN, the NASW supports the fulfillment of the 1% for Children initiative as intended in the *Truth in Sentencing* legislation. This funding should be made available to make home visiting and family resource services available to all parents of newborn children. We believe that this funding should: be new money, be dedicated to primary prevention, provide enough flexibility for comprehensive, community wide involvement in the development and delivery of services.

W-2

The NASW Wisconsin chapter supports the following improvements in W-2 to be incorporated into the budget bill:

1. The NASW supports the recommendations of the SSI Parents Coalition for families headed by a parent or parents on SSI. The added cost to the Caretaker Supplement program is small compared to the security it offers families that are already burdened by the stress of a disabled parent. We also recommend that this increase start July 1, 1999 rather than the October 1, 1999 start date in the current budget proposal.
2. Members of the NASW have several concerns regarding the contract process for W-2 agencies. NASW recommends the following: W-2 agencies should be required by contract to inform clients of all options and services available to them and the agencies should be required to follow up on clients once they leave W-2 to ensure that they are gaining independence and self-sufficiency, as opposed to simply leaving the "welfare rolls". Explicit guidelines and standards for follow-up should be provided in the contract. In addition, broad-based community participation, including input from clients, advocates, service agencies and community advisory groups should be a required part of all W-2 contract development. All W-2 agencies should be required by contract to participate in an ongoing basis with such groups. Explicit guidelines and standards for collaboration with community groups and individuals as well as for the utilization of their input should be provided in the contract.
3. The NASW supports the Governor's budget initiatives to lower child care co-payments; however, we recommend that the child care co-payments be waived for W-2 participants living below the poverty line, minor parents, kinship care relatives, and foster parents.

Testimony submitted to the Wisconsin Public Hearings of  
Joint Finance Committee in Madison  
on April 15, 1999

by Kim Barovic on behalf of NASW - Wisconsin

attachments: position papers from NASW-WI



Wisconsin Chapter, National Association of Social Workers  
1999 Lobby Day

MAKING W-2 WORK

NASW-WI believes that W-2 (Wisconsin Works) must be modified if it is to succeed as a program to move people out of poverty and into economic independence. Although W-2 was "designed to reinforce behavior that leads to independence and self-sufficiency," its success has been defined in terms of caseload reduction instead of client independence and self-sufficiency.

Problems with W-2

Simply reducing the welfare rolls is not the stated goal of W-2. We must look beyond this to the genuine welfare, the health and well-being, of all who live in Wisconsin. We must ask ourselves and our elected representatives, what do we have to offer in terms of career jobs, living wages, education, and support to families to make independence and self-sufficiency a reality and not just a catch phrase? For those for whom independence and self-sufficiency are not entirely attainable goals, how can we as a democratic society demonstrate our humanity, our compassion, and our commitment to basic human and economic rights?

Has W-2 provided the means for those leaving welfare to become independent and self-sufficient? The recently released Department of Workforce Development (DWD) survey of those who have left showed that 38% of the former participants were unemployed. This indicates a critical shortfall in a program designed around the slogan of "Only work pays." Such hurdles as underemployment and lack of living-wage jobs, the scarcity of quality, affordable daycare, and insufficient training and education continue to prevent many families from reaching independence and self-sufficiency. Many have turned to private and faith-based charities, community agencies, and extended families simply to survive, placing greater strains on an already overburdened network of support *without achieving the goals of W-2*. Others have simply vanished from the rolls, their fate unknown. DWD has the responsibility for the implementation of W-2 and must be held accountable to its stated goals.

Recommendations

To help accomplish the stated goals of W-2 of helping families to become independent and self-sufficient, NASW-WI recommends the following:

- Evaluate the success of W-2 by a comprehensive measurement of clients' independence and self-sufficiency.
- Require extensive training for W-2 caseworkers so they are prepared to conduct comprehensive, individualized assessments of applicants for barriers to self-sufficiency, including such areas as education, housing, child care, domestic violence, substance abuse, and mental and physical disabilities.
- Allow W-2 participants up to 30 hours per week for education and training (such as high school, GED, post-secondary, life skills, parenting, AODA, and ESL) along with 10 hours per week of work activities. Also, parents still eligible to attend high school must be able to do so without an added work requirement.
- Waive the child care co-payment requirements for W-2 participants living below the poverty line, minor parents, kinship care relatives, and foster parents. Follow the DWD recommendations to reduce co-payments in the first month of work; pro-rate co-payments for children in part-time child care; and cap the maximum payments for child care at 10% of income.
- Restore the fair hearing process and allow participants to continue to receive benefits pending a decision.



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**PREVENTION OF CHILD ABUSE AND NEGLECT**

Today, one can rarely read the newspaper or watch television news without being jolted by stories of beaten, sexually abused, or severely neglected children. In Wisconsin, more than 46,000 cases of child abuse and neglect are reported each year. The people of Wisconsin clearly recognize the need to protect children, and are willing to support prevention programs. In fact, a 1993 survey of Wisconsin voters showed that 88% saw a need for prevention programs, and 80% believed prevention would save taxpayers money in the long run.

It is important to understand that most maltreated children grow up to lead normal adult lives, and they don't grow up to abuse their own children or others. However, studies show abused and neglected children are all at *greater risk* for mental health problems, suicide attempts, alcohol abuse, drug abuse, and poor school performance. Perhaps most disturbing is that physically abused and neglected children are *significantly more likely* than children with no histories of maltreatment to commit violent crimes as juveniles and adults. Pronounced differences between abused and neglected children <sup>and</sup> their non-abused counterparts can begin to emerge as early as age 8 or 9.

Neglect is by far the most common type of maltreatment reported to child protection authorities, accounting for over half of all national child maltreatment reports and 43% of reports in Wisconsin (1996). While other types of abuse are episodic in nature, neglect generally involves a pervasive and ongoing pattern of behavior. Although there is not a single type of parent who neglects his/her child, researchers have observed some common characteristics: depression, isolation, history of being neglected as a child, drug and/or alcohol use, and stress. National statistics show that neglect disproportionately affects infants and preschoolers, who are at their most vulnerable developmental stage. Recent research on infant brain development suggests that the impact of the environment on a newborn is dramatic: without affection, attention and proper social interactions, the child's brain will not develop properly.

**Recommendations**

• **Expand Home Visiting Programs**

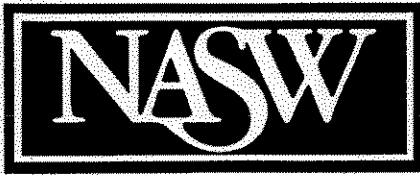
High-quality home visiting programs which start working with families as soon as the child is born have proven to be effective in preventing child abuse and neglect. The programs are successful because they help parents manage the stresses of raising children before unhealthy patterns develop. NASW-WI recommends the expansion of state supported home visiting programs so that they are available in every county of Wisconsin.

• **Collaboration Between Home Visitors and W-2 Financial Employment Planners**

NASW-WI believes that by working together, home visitors and W-2 Financial Employment Planners can double their impact by providing information and assistance at the local Job Centers or W-2 agencies while reinforcing and extending the message of self-sufficiency in the home environment. By educating parents on parenting skills, family budgeting, interpersonal skills, time management, problem-solving strategies and finding quality child care, the W-2 program and home visitation programs can help individuals maintain employment while encouraging healthy family relationships and child development.

• **Fulfill the Commitment of 1% for Prevention**

Last June, when the Governor signed in to law Act 283, the *Truth in Sentencing* legislation, including the bipartisan-supported "1% for Children" amendment, Wisconsin became the first state in the nation to link crime reduction and child abuse prevention. The amendment calls for the allocation of the equivalent of 1% or greater of the Department of Corrections budget toward the prevention of child abuse and neglect. NASW-WI proposes that the funding for this amendment be new money (or money not already allocated to prevention); that it be dedicated to the primary prevention of child abuse; and that it provide local jurisdictions with the flexibility to design their own programs.



Wisconsin Chapter, National Association of Social Workers  
1999 Lobby Day

**PARITY FOR MENTAL HEALTH AND SUBSTANCE ABUSE**

The Wisconsin Chapter of NASW believes in the need for a Wisconsin Mental Health and Substance Abuse Parity Law. The Federal Mental Health Parity Act of 1996 (P.L. 104-204) was a first step toward equal insurance coverage for persons with mental illness, but the loopholes in that Law mean that, in Wisconsin, there is no substantive change in health insurance coverage for people with mental illness or substance abuse issues.

Over the past 20 years, research has demonstrated the relationship between mental illness and abnormalities in the brains of affected individuals. No one blames a person suffering from a brain disease. At the same time, treatment for brain diseases has improved tremendously. A NIMH study shows the current success rate for the treatment of clinical depression is 80-90%, whereas the overall success rate for cardiovascular disease is only 45-50%.

More than 70% of people who currently use illicit drugs which put them at risk for developing an addiction, as well as 75% individuals who are alcoholics are employed. Most employer-provided insurance policies today discriminate against people with AODA issues requiring greater patient burden for cost sharing, co-payment, and deductibles, while offering less coverage for number of visits or days of coverage and annual and lifetime dollar expenditure limits for treatment. According to the Bureau of Labor Statistics, in 1995 about 80% of employees working for medium and large employers have health plans that cover a minimum level of medical treatment. However, fewer than 7% of these employer provided health plans covered AODA treatment to the same extent as other medical conditions. If alcohol and drug addiction is not treated when an individual has employer provided insurance, the costs of addiction do not go away. They simply become a negative externality, causing costly problems in other areas of public and private systems, such as the Medicaid, Medicare and Corrections systems. Costs may eventually shift back to the private health system which must deal with alcohol and drug addiction-related accidents and diseases when treatment could be made available before such problems surface.

**Parity Will Not Increase Insurance Expenses**

The following studies show that insurance costs will not rise with the inclusion of mental health and substance abuse coverage.

A recent study by the Federal Substance Abuse and Mental Health Services Administration (March 1998) concludes:

- State parity laws have a small effect on premiums. cost increases have been lowest in systems with tightly managed care and generous baseline benefits.
- Employers have not attempted to avoid parity laws by becoming self-insured, and they do not tend to pass on the costs of parity to employees.
- Costs have not shifted from the public to the private sector. Most people who receive publicly funded services are not privately insured.

A report from the National Advisory Mental Health Council (May 1998) concludes:

- In systems already using managed care, implementing parity raises health care costs by less than 1%<sup>9%</sup> over one year.
- Introducing managed parity in systems not using managed care leads to a 30-50% reduction in total mental health costs over one year.
- Maryland reported a 0.2% decrease in the proportion of total medical premium attributable to the mental health benefit after the implementation of full parity.

A 1997 Rand Corporation Study concluded that removing limits on inpatient days and outpatient visits will increase costs by less than \$7 per enrollee per year.

Finally, since all employees pay the same premium for their health insurance coverage, it is discriminatory to restrict the treatment for mental health and drug and alcohol addiction when treatments for other chronic illnesses are not restricted. People with brain diseases should have the same health insurance coverage as people with other physical health illnesses.

**Recommendation**

NASW -WI believes that the Wisconsin Legislature should pass a new law and regulations that require mental health and substance abuse insurance coverage.



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HEALTH AND LONG TERM CARE

Health Insurance

Almost half a million people in Wisconsin do not have health insurance, and the number of uninsured is increasing. Over 1.5 million people in the state were either denied health insurance, had certain conditions excluded, or paid higher premiums because they had pre-existing conditions. There have been attempts at both the state and national level to secure universal health care coverage for all residents.

Managed Care

Most people in Wisconsin (84%) have their health care through a managed care plan. Although many are satisfied with their managed care plan, the following problems have occurred: limitations on benefits; prior authorization required to receive specialized treatment; restrictions in receiving care from specified providers; inability to receive emergency care without authorization; emergency care limited to specific facilities; not all prescription drugs are available; special provisions and limitations on mental health services; no coverage out of plan area; and restrictions in the availability of grievance and appeal procedures. The 1997-98 State Legislature adopted some changes in managed care, but left out many important protections.

Long Term Care

About 260,000 residents of Wisconsin over age 15 have a permanent or long term disability, and one-fourth of them live in poverty. About a third of these people need to help with three or more basic activities of daily living, such as bathing, dressing, moving around, toileting, eating, or transferring from bed to chair. Another third need help with one or two of these activities of daily living, while the remaining third need help with activities such as managing medications, meal preparation, household chores and using the telephone.

Most of the long term care is provided by family or friends. In Wisconsin, the formal system includes 400 facilities, such as nursing homes. There are 1,300 community-based residential facilities and over 100 county and thousands of voluntary and proprietary agencies providing these services. Since many living in nursing homes have exhausted their resources paying for their care, about 60% of those in nursing homes are covered by Medicaid. The Community Options Program, which provides services to people who remain in their own home, has a waiting list of about 9,000. More than \$2 billion in government funds are required to pay for these services. There has been an effort to reorganize long term care in Wisconsin. This has been complicated by capping the funding, including health care and contracting for the administration of long term care.

Recommendations

- Support a Universal Health Care program for Wisconsin residents.
- Support Badger Care, which would provide more people with health insurance coverage and institute sliding scale fees for health care.
- Support consumer protections in managed care, including an independent appeals procedure.
- Permit enrollment in managed care plans, regardless of current coverage or pre-existing conditions.
- Support a comprehensive, coordinated long term care system in Wisconsin under public auspices.



Wisconsin Chapter, National Association of Social Workers  
1999 Lobby Day

**CIVIL RIGHTS FOR LGBT CITIZENS**

It is the position of the National Association of Social Workers that same-gender sexual orientation should be afforded the same respect and rights as other-gendered orientation. Discrimination and prejudice directed against any group are damaging to the social, emotional, and economic well being of the affected group and the society as a whole. Denial of legal rights reinforces and legitimizes homophobic and other acting-out behavior of those predisposed toward prejudice, discrimination, and violence. (Social Work Speaks, 1997: NASW Press, 201-202).

NASW WI believes it is essential that the basic rights and responsibilities afforded to heterosexual citizens are conferred upon lesbian, gay, bisexual and transgendered (LGBT) persons in order to obtain true equality. The following is a description of some of the issues facing LGBT persons in Wisconsin.

**Domestic Partnership**

While LGBT persons pay the same taxes as their heterosexual counterparts, they are denied the same civil rights and responsibilities that marriage confers. It costs gay and lesbian couples thousands of dollars to replicate just some of civil protections that heterosexual couples receive for the cost of a marriage license. Some basic benefits and responsibilities denied to gay and lesbian couples include:

- Health insurance under their partner's policy
- Health insurance for their child if they are the non-biological or adoptive parent
- The ability to adopt their partner's children
- Responsibility for child support or alimony in cases of a dissolved relationship
- Taxation and inheritance rights

**Children of Gay and Lesbian Parents**

At a time when Wisconsin is receiving national attention for enacting policies aimed at bettering the lives of children, it is important that one group does not go unnoticed: the children of LGBT parents. The familial make-up of our society is undoubtedly changing, and many children are being raised in households where the primary caregivers are not married to each other. This leaves the children in legally precarious situations, threatened with losing all caregivers or support if something should happen to their legal parent or the adult's relationship. Some essential familial securities that should be included in Wisconsin law are the following:

- Adoption of a child into a loving home by two unmarried adults.
- Adoption of a child by a parent-like figure who is not married to the legal parent.
- Visitation or guardianship of a child by a parental figure in the event of death of the child's legal parents.
- Responsibility for child payments and visitation by parental figures in instances of separation.

**Recommendations**

- In the interest of fairness, justice and economics, it is important that Wisconsin lawmakers support domestic partnership legislation.

To ensure that all children have equal protections under the law, Wisconsin lawmakers should support and pass legislation that is designed to give the protections listed above to children who have few rights under current law.

RICE DEVELOPMENT



DIVISION OF VOCATIONAL REHABILITATION  
 2917 International Lane  
 P.O. Box 7852  
 Madison WI 53707  
 (608) 243-5600  
 TTY# (608) 243-5601

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Name

Kathy Brockman

FAX Number

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Location

Badger

Room Number

Phone Number

414-258-9200

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## MESSAGE:

Hi Kathy -  
 Here is the fact sheet & the  
 dates & places for the joint  
 Finance Committee Hearings.

Jane



REGIONAL HEARINGS OF THE  
LEGISLATURE'S JOINT FINANCE COMMITTEE

3/9/99

March 26, 1999

Brown County Public Library  
Auditorium  
515 Pine Street  
Green Bay  
10:30 am - 5:00 pm

April 8, 1999

Jl Case High School  
Auditorium  
Racine  
10:30 am - 5:00 pm

April 13, 1999

UW Stevens Point  
University Center, Alumni Room  
Stevens Point  
10:30 am - 5:00 pm

April 14, 1999

Osceola High School  
Gymnasium  
Osceola  
10:30 am - 5:00 pm

★ April 15, 1999

State Capitol  
Room 411 South  
Madison  
10:30 am - 5:00 pm*Register to Testify After  
9:30 AM*





**COUNCIL ON BLINDNESS**  
 2917 International Lane  
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 Madison, WI 53707-7852  
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### **ADEQUATE FUNDING FOR SERVICES FOR THE OLDER BLIND--April 1999**

Older people who are blind or visually impaired should have the opportunity to maintain their independence in their homes and remain active in their communities. Inadequate state funding for the elderly blind or visually impaired causes many of these people to depend on their families and the State for costly long-term living arrangements.

#### **Current Services and Funding**

Rehabilitation Teachers employed by the State of Wisconsin, Department of Health and Family Services, Office for the Blind, teach older blind people how to maintain their independence. This includes techniques for communicating, mobility, and work in the home, such as food preparation, budgeting, and record keeping.

Fifteen Rehabilitation Teachers for the blind and visually impaired serve approximately 1,000 people statewide with an annual budget of about \$69,000 for travel and adaptive equipment. This equals \$69.00 per client as opposed to the approximately \$100 per day, or \$3,000 per month that can be spent on assisted living facilities.

As of July 1, 1998, the Rehabilitation Teaching program lost approximately \$80,000 of funding from the Division of Vocational Rehabilitation. With this change, client services have decreased.

#### **Population**

In 1990, approximately 90,000 Wisconsin residents were estimated to be blind or severely visually impaired. Of this number, nearly 75,000 were over the age of 55. Estimates from the Wisconsin Demographic Services Center show the population of our state will increase from about 4.9 million in 1990 to about 5.7 million in 2020. In addition, baby boomers will be entering the ranks of the elderly. Thus, it is certain that the number of people eligible to receive vision rehabilitation services will dramatically increase.

The American Foundation for the Blind 1995 data show that almost 1.1 million Wisconsin residents were over the age of 55, with the following breakdown:

Age	Visually Impaired	Severely Visually Impaired
Over 55	10 percent	2 percent
Over 65	13 percent	2 percent
Over 75	19 percent	4 percent
Over 85	29 percent	7 percent

#### **Legislative Action Requested**

The Wisconsin State Legislature should build into the base of the budget for the Office for the Blind \$100,000 to restore lost revenue and adequately fund transportation and adaptive equipment to serve the older blind and visually impaired population in the state.

Charlja/winword/cob/AARP

## ADEQUATE FUNDING FOR SERVICES FOR THE OLDER BLIND

### PPORPOSAL SUMMARY

State services for older blind adults are inappropriately funded by the state of Wisconsin. As a result many people who are older and blind or visually impaired will not maintain their independence but become dependent upon their families for basic needs and the state for funding of costly long-term living arrangements. More funding should be allocated to services that increase independence and the likelihood of the client remaining in their own home rather than costly nursing homes or assisted living placements.

The fifteen FTE rehabilitation teachers are funded 50% GPR and 50% Federal Vocational Rehabilitation dollars. The VR dollars are in jeopardy for long term funding. ***The total transpiration money for the rehabilitation teachers this SFY was NOTE:?? AND THE TOTAL MONEY FOR EQUIPMENT FOR THEIR CLIENTS WAS note:??.*** These rehab teachers serve approximately 1000 people each year with these limited funds. 1000 people that sustained independence and saved the state costly long-term funding obligations. The state has not appreciably added to this service program in over fifteen years and the population continues to grow.

Beginning on July 1, 1998 the rehabilitation teaching program lost approximately \$80,000 of funding from the Division of Vocational Rehabilitation, DVR. (This program used to be in DVR but was relocated to the Division of Supportive Living in July 1996). With this change, funding losses are accumulating.

### LEGISLATIVE ACTION

The Wisconsin State Legislature needs to restore this lost revenue and adequately fund the transportation and client-equipment budgets. An additional \$100,000 needs to be allocated to this programs in each year of the next biennium to adequately fund services to older blind or visually impaired adults.

## RATIONALE

Governor Tommy Thompson stated in his 1999 State of the State Address the need to make the lives of senior citizens more secure through long-term care in their own homes. Older people who are blind should have the opportunity to maintain their independence and remain in their own homes - if not for the dignity of a human being, for the economic benefit to the state. These people have been managing their personal affairs, taking care of their homes, cooking and involved in the leisure of their choice for many years. When their vision becomes dramatically reduced, tragically most of them will stop doing things for themselves. Often times they or their families seek a nursing home or other assisted living placement. This does not have to happen. Older persons who are blind or severely visually impaired can live independently.

The Office of the Blind (in the Division of Supportive Living) has fifteen rehabilitation teachers located across the state. It is their job to teach older blind people how to maintain their independence. They teach communications, cooking, cleaning, budgeting and anything else the customer needs to learn to remain in his/her home. In addition to teaching people how to maintain their independence without sight they will provide special equipment that will be helpful (e.g., talking clocks, magnifiers, kitchen utensils). The teaching occurs in the client's home; thus it is an itinerate program.

**STATISTICAL EVIDENCE:** In 1990, approximately 90,000 Wisconsin residents were estimated to be blind or severely visually impaired. Of this number, nearly 75,000 were over the age of 55. Given that estimates from the Wisconsin Demographic Services Center show the population of our state will increase from about 4.9 million in 1990 to about 5.7 million in 2020 and that baby boomers will be entering the ranks of the elderly, it is certain that the number of people eligible to receive vision rehabilitation services will dramatically increase. According to 1995 statistics from the American Foundation for the Blind, almost 1.1 million Wisconsin residents were over the age of 55. Of these, 10 percent were visually impaired and 2 percent were severely impaired (includes blindness). Of those people 65 years of age and older, 13 percent were visually impaired and 2 percent were severely visually impaired. In the 75 and over age group, 19 percent

were visually impaired and 4 percent were severely visually impaired. Of those folks 85 years of age and older, 29 percent were visually impaired and 7 percent were severely visually impaired.

## **Public Hearing**

### **Provisions in the Budget Bill [1999 Assembly Bill 133]**

#### **Relating to**

#### **The Health Insurance Risk Sharing Plan (HIRSP)**

**Reference:** s. 20.435 (4) (af)  
s. 20.435 (4) (ah)  
s. 20.435 (4) (gh)

Sections 417, 418, 2256-2278, and 9123 (2), pp. 427, 1052-1058, and 1406

**Place:** State Capitol, Room 411 South

**Date & Time:** April 15, 1999, 10:30 a.m.

**Testimony of:** Robert T. Wood  
Corporate Vice President, Government Relations  
Wisconsin Physicians Service Insurance Corporation (WPS)  
  
Member, HIRSP Board of Governors

My name is Robert Wood. I am Corporate Vice President of Government Relations for Wisconsin Physicians Service Insurance Corporation (WPS). I have served on the HIRSP Board of Governors for more than 11 years. I have been responsible at WPS for review of HIRSP operations, administration and legislation since the plan was first enacted nearly twenty years ago as part of the Laws of 1979.

I am speaking on the subject of proposed changes to the HIRSP statutes in the budget. I speak as a member of the HIRSP Board, but I am not speaking for the HIRSP Board.

I am submitting brief written testimony and I will try to be even briefer in speaking here.

In 1997, this Committee restructured HIRSP funding based on agreements reached with insurers, providers, and the Department of Health and Family Services.

The basic agreements were that \$6 million GPR in the first half of calendar year 1998 and \$12 million in GPR in the current fiscal year would be appropriated to partially fund the HIRSP program. After application of GPR funding, full premium payments would be set to fund 60 percent of program costs and insurers and providers would each fund 20 percent of the remaining unfunded costs. The Department would track and fund financial performance of the plan against budget, and there would be a reconciliation process to balance out any variances from statutory funding shares. You transferred the program from OCI to the Department of Health and Family Services, and asked

DHFS to take care of these tasks.

The new funding arrangements translated into an immediate 15 percent rate cut for the people in the plan. HIRSP rates dropped from 192 percent of a standard risk rate to 150 percent. For many individuals aged 60 or more who make up the largest age group in the plan this meant close to \$1,000 in savings on an annual basis.

In the current fiscal year, we were able to keep premiums at 150 percent of a standard risk rate. I'm confident they will remain at 150 percent in the next fiscal year. A rate increase will still be needed, but only to reflect the marketplace increase in the standard risk rate. This means the new funding arrangements are working well for the people in the program who themselves pay the largest share of program costs.

There have been a number of problems in the administration of the HIRSP program since it was transferred to DHFS, particularly with the Department's inability until very recently to provide data on financial operation of the plan against budget, or to provide information on plan enrollments and demographics. I don't want to dwell on these problems, because I believe that some of the most serious problems are close to being fixed.

I raise the subject only because, when you transferred the program to DHFS, you reduced the ability of the HIRSP Board of Governors to effectively oversee the operations of HIRSP and approve policy changes in the program. I believe that if you had kept the HIRSP Board the same strong Board it was for nearly 18 years when the plan was administered at OCI, some of the problems we have had with the plan over the past 15 months might not have happened, and those that couldn't have been avoided might have been paid attention to and fixed earlier.

This said, I have three recommendations for changes to the HIRSP statutes in the current budget bill.

1. My first recommendation is that you make the Board a stronger Board again.

HIRSP is a partnership between the private sector, and the government. In this partnership, the people enrolled in the plan and the insurers and providers who share in plan costs pay the greatest share of the costs of the HIRSP program. They deserve a stronger voice in how their funding of the program under the statutes is accounted for and reconciled.

I think I do not have to tell you that the Department wishes the Board to speak in a very small voice and only as an advisory body. I think if the Board is to be limited to a strictly advisory role, you might as well not have a Board at all.

The Board has historically played a strong role in representing the interests of the people who are enrolled in the plan. To the extent that you have a weak board, it is these people who lose the most in terms of *not* having a voice in the operations of the plan.

- A. Feeling as I do, I would recommend that you delete those sections in the budget bill, as originally introduced, that would further weaken the Board.
- B. Next, I would recommend that the Board needs a stronger voice in at least six areas.

- (1) Development and approval of the HIRSP budget.

- (2) Oversight of financial management of the plan against budget.
- (3) Oversight of changes in HIRSP policy, including proposed changes in HIRSP benefits and other changes to statutes.
- (4) Reporting of data in HIRSP monthly reports, and other information of interest to the Board.
- (5) Assignment of work and scheduling of meetings of Board committees and sub-committees.
- (6) Development and release of reports specified in statutes as reports by the Board to the Legislature and to the Governor.

C. Finally, representation on the Board needs to be adjusted in two areas:

- (1) The Secretary of DHFS chairs the Board. Statutes should specify that no appointed member of the Board should be an employee of DHFS.
- (2) Statutes should specify that at least one of the consumer representatives on the Board must be a participant in HIRSP.

Planning documents relating to HIRSP are starting to talk about turning HIRSP into a "Medicaid look-alike program," but HIRSP is an insurance program, not a categorical benefits program. As the Department has learned, it is a very different program from Medicaid. I think you should want to keep it that way.

In January 1999, HIRSP costs were running about \$38 million on a fiscal year basis. The Department (as of yesterday) now estimates that program costs have increased and will be closer to \$46 million at the end of this fiscal year.

The HIRSP population is not a "Medicaid look-alike" population. There were just under 7,000 individuals enrolled in the plan in January. On average close to 60 percent of the HIRSP population is female. More than 60 percent of the people covered under the plan are over age 50. Nearly 30 percent are over age 60. Between 35 and 40 percent of the people insured by HIRSP report annual household incomes under \$20,000 and receive subsidies that help them pay premiums and deductibles.

These people could use a stronger Board to speak on their behalf. When problems occur, the Board ought to have sufficient oversight authority to ask for and receive explanations and information and to request action to fix problems, but we don't.

2. My second recommendation speaks to the Department's most recent legislative proposal.

- A. The Secretary of DHFS outlined new changes he wishes to make to HIRSP in recent testimony before this Committee. Since then, as I understand it, the Secretary has modified his proposal.

The Secretary reviewed the most recent outlines of his legislative proposal at a meeting of the HIRSP Board yesterday.

At that meeting, the HIRSP Board agreed that new legislative language requested by the Secretary to give the Department greater flexibility in managing and reconciling financial performance of the plan is needed and should be drafted.

The proposed new language, as I understand it, would allow the Department to determine variances in the statutory 60%/20%/20% funding of program costs compared to actual funding on a calendar year basis, and make adjustments to reconcile those variances in the immediately following fiscal year.

The Secretary also discussed proposed changes in processing of prescription drug claims, some of which appear to the Board to be reasonable.

But the Board asked to be provided with more information relating to reductions in benefits, which some members of the Board would oppose.

3. Finally, I do think that I can speak for the Board in asking that you consider restoring the \$2,000,000 in GPR funding for HIRSP that was cut in the budget.
  - A. If these funds were restored, the appropriation under s. 20.435 (4) (af) would increase from \$9,900,000 to \$11,900,000 in each of the next two fiscal years.

Thank you for your time and patience.

I would be pleased to try to answer any questions you may have.





KATHLEEN FALK  
DANE COUNTY EXECUTIVE

## Area Agency on Aging of Dane County

Susan Crowley – Director, Department of Human Services  
Rita Odegaard – Administrator, Area Agency on Aging

April 14, 1999

Good Afternoon: My name is Nell Mally and I am the Chair of the Area Agency on Aging of Dane County. One of our main tasks is to advocate for the 46,000 older adults who live here. I have also had 20 years' experience managing an agency which provides services for older adults, including adult daycare and senior center services along with case management, nutrition, transportation, and in home care. And I have taught Gerontology classes at MATC for a number of years. So, I speak with some real sincerity to you!

In the early 80's we courted small and large local communities to supplement the county and state dollars that we received. And that was good. Generally we operated with a 2 to 3 percent increase each year, even though we were seeing a hefty increase in the number of people that we served.

Today the picture is very different. We are working, not only with a greater number of older adults, but also with their family members who are challenged by the complexities of helping to care for a mom who seems to be growing confused, can't keep up with her medications, doesn't understand or retain what her physician says to her, isn't eating regularly and who wanders the halls of her apartment building looking for help from her frail neighbors. And not only are we trying to cope with increasing numbers of older adult needs, but we are being expected to do it with major cuts in state funding. It is highly possibly that you will see agencies around the state fold when they can no longer maintain wages and services with dwindling dollars.

You know, with the inception of Social Security in 1935 and with the growing awareness of massive injustices lying beneath the gloss of prosperity in the 50's and the 60's, the government undertook a program and a philosophy of support of older persons that included Medicare and Medicaid and continues into today. We need to supplement our programs in proportion to the growing needs of the elderly...not cut them by even a penny.

In response to this, we are asking you (actually giving you an opportunity!) to restore some of the cuts made in the Governor's budget. And I like Kathleen Falk's suggestion of using some of the tobacco settlement money to make up for some of the human service losses that we have taken.

1. Long Term Care Redesign must be funded and moved ahead for the good of the older people in Wisconsin. By the way, we do not care for the term "Family Care" because it is a name with such limitations. Long Term Care certainly includes family care, but it also includes other services and arrangements in the community such as nutrition, adult daycare, supportive home care, transportation, and so on.

2. We need money NOW for the Community Options Program. This plan is actually just a shadow of itself in that there are 10,000 people on the waiting lists. Many elderly die while they are waiting for some kind of service.
3. We need an additional \$3 million put into the nutrition program. Sometimes the single service that keeps an older person in their home is a hot noon meal, whether delivered or eaten at their neighborhood meal site. In addition to an anticipated increase in the number of meals needed, we need funds to provide nutritional supplements or a second daily meal for especially vulnerable, and oftentimes isolated, older adults. And we need nutrition intervention services to help stave off premature nursing home admittance.
4. If you are an older person living in the Village of Brooklyn, the last time I checked there is one RSVP driver available on a limited basis to take you to a Madison physician appointment, and if you need groceries you could go to the closest store (which is in Oregon) only on Thursdays at 12:45 p.m. Heaven forbid that it conflicts with the physician appointment! Transportation systems are woefully inadequate in rural areas. Certainly dollars are needed to bolster the present system where it exists and to establish a system where there is none. Perhaps additional money could be put into shared ride systems.

Yesterday I received a memo from Dane County Human Services saying that the Director has prepared a statement for Dane County legislators describing "\$2.6 million in service reductions that might be needed in CY2000 given the stated and federal funding reductions and inflation. Roughly \$1.5 million would be within Adult Community Services."

We are most hopeful that we can influence you to authorize additional state funding so that these reductions will not come to be.

Thank you.

**TESTIMONY BEFORE THE JOINT COMMITTEE  
THURSDAY, APRIL 15, 1999  
WISCONSIN STATE CAPITOL  
MADISON, WISCONSIN**

Good ~~morning~~/afternoon Mr. Chairman. My name is Diego Camacho, Jr.. I am a licensed funeral director. I own and operate funeral homes and crematory in Darlington and Monroe.

Whenever our funeral homes serve a so called welfare funeral, the state reimburses the county where the deceased resided and died \$1000. The county then reimburses our funeral home \$1000 plus cemetery expenses. Our cost for basic services of funeral director & staff, casket, facilities and other miscellaneous merchandise is well above the \$1000 reimbursement. It was in 1992, I believe, we had an increase. However, in that increase please note that the casket is provided by the funeral home.

I thank you for addressing this shortfall. I strongly urge you to support the increase we are requesting from \$1000 to \$2500.

I have been told that most nursing homes are reimbursed at least 90% or so of their operation expenses. The reimbursement I receive is 20-30% of my costs. We want to be able to serve the needs of these families! However, I do not believe that our funeral home can continue to take these losses and maintain the level of care to the deceased person and their grieving family members.

The other issue I want to address is a similar request to the first one. It is an increase of the irrevocable funeral trust of \$2000 to \$3500. Again, I believe this was addressed in the 1991-1993 budget. The \$2000 amount that an SSI/MA recipient can set aside is considerably less than our operating expenses. There may be numerous funeral homes in other communities that

exceed this \$3500 increase already. I feel that at least this is a step in the right direction. By allowing this increase of \$3500 you will be giving those grieving families a better opportunity to give their loved one a respectful and dignified funeral service while helping them in the grieving process.

The other side of the coin, if you will, as I see it is this. By increasing this amount to \$3500 you will encourage families and/or funeral directors to perhaps fund the irrevocable funeral in a local financial institution in their own surrounding communities. I know of various funeral homes that prefer to trust in the banking institutions of their particular area where they have the funeral home. Otherwise, I believe the exodus to insurance funded funerals will be inevitable. It will be a matter of survival. Insurance funded funerals have no set limits. Families can select the funeral of choice and fully fund it. To some families and/or funeral homes this is a preferred choice and perhaps the right one. For others it may not!

Recovery Act of 1993 requires any excess amount to revert back to the county or state. It is my understanding that whenever a funeral is funded by insurance then the state/county has NO recovery claims on the excess money. Some funeral homes may have operating procedures that they follow whenever this occurs with insurance.

With the irrevocable funeral service trust the excess amount reverts back to the state/county.

From my experience in the 20 years as a funeral service practitioner I can give testimony to the fact that many families we serve achieve a level of peace whenever they prearrange and/or prefund their funeral services.

For these reasons I hope you will support both of these increases. I believe our bereaved families will benefit as well as our funeral profession.

**Thank you for the privilege to speak to you today!**

**Any questions?**

**Thank You.**

TO: Joint Committee on Finance Members

FROM: Eugene Lehrmann  
Ellen Rabenhorst  
David Slautterback

Representing the Following Organizations:

AARP  
Coalition of Wisconsin Aging Groups  
Wisconsin Retired Educators Association  
Wisconsin Council of Senior Citizens  
Wisconsin Alzheimer's Chapter Network  
Wisconsin Association of Area Agencies on Aging  
Wisconsin Association of Aging Unit Directors  
Wisconsin Council of Churches  
Milwaukee Consortium of Service Providers  
Dane County Elderly Services Network

DATE: April 15, 1999

SUBJECT: State Budget Priorities for the Elderly

On behalf of the organizations listed we urge your support for the following priority issues:

1. Family Care – We support the Family Care pilot projects in the proposed budget. Family Care is extremely important to older persons because it provides one-stop shopping (Resource Centers) for older persons and their families, and it creates equal access to home and community long-term care services as it does to nursing home care. Because there is no system serving older persons, Wisconsin still provides 77% of long-term care to the elderly in nursing homes. Family Care will give many more older persons the opportunity to remain in their own homes.
2. Community Options Program (COP) – While we pilot Family Care, we urge you to provide additional COP dollars to provide hope to people on waiting lists in the remaining 63 counties that are not Family Care pilots in this budget. Nursing home utilization has been going down in Wisconsin and is projected to continue to decrease in this budget. Additional funding for COP will help assure the projected decrease and Medicaid savings in nursing home costs.

3. Ombudsman – We urge your support for eight additional Ombudsman positions (four in each year of the budget) to serve the long-term care population in Wisconsin of over 90,000 people. This would put Wisconsin at approximately twice the national recommended standard of one Ombudsman for every 2,000 long-term care clients (i.e., 1:4,000).
4. Long-Term Care Workers – We support wage pass-through legislation that will provide increases to the lowest paid long-term care workers; i.e., Personal Care workers and Certified Nurse Aides.
5. Elderly and Disabled Transportation – From FY96 through FY 99 the DOT budget has increased by \$387.4 million while the Elderly and Disabled Transportation program has increased by only \$1.2 million or three-tenths of one percent (.003%) of the overall increase. We support an increase of \$8 million a year in the E&D Transportation program. Even with this increase the program would still be less than 1% of the total DOT budget.
6. Elderly Nutrition Program – State funding for the Elderly Nutrition Program has not increased since 1994 despite a shift toward more costly home delivered meals to accommodate the growing population of people age 85 and over. We urge an increase in this budget.
7. Alzheimer's Family and Caregiver Support Program (AFCS) – This program has not received an increase in funding since it was initiated in 1985. We support an increase of \$1.8 million to eliminate waiting lists (750 people) and to serve additional families.

## **Public Hearing**

### **Provisions in the Budget Bill [1999 Assembly Bill 133]**

#### **Relating to**

#### **The Health Insurance Risk Sharing Plan (HIRSP)**

**Reference:**

s. 20.435 (4) (af)  
s. 20.435 (4) (ah)  
s. 20.435 (4) (gh)

Sections 417, 418, 2256-2278, and 9123 (2), pp. 427, 1052-1058, and 1406

**Place:**

State Capitol, Room 411 South

**Date & Time:**

April 15, 1999, 10:30 a.m.

**Testimony of:**

Robert T. Wood  
Corporate Vice President, Government Relations  
Wisconsin Physicians Service Insurance Corporation (WPS)  
  
Member, HIRSP Board of Governors

My name is Robert Wood. I am Corporate Vice President of Government Relations for Wisconsin Physicians Service Insurance Corporation (WPS). I have served on the HIRSP Board of Governors for more than 11 years. I have been responsible at WPS for review of HIRSP operations, administration and legislation since the plan was first enacted nearly twenty years ago as part of the Laws of 1979.

I am speaking on the subject of proposed changes to the HIRSP statutes in the budget. I speak as a member of the HIRSP Board, but I am not speaking for the HIRSP Board.

I am submitting brief written testimony and I will try to be even briefer in speaking here.

In 1997, this Committee restructured HIRSP funding based on agreements reached with insurers, providers, and the Department of Health and Family Services.

The basic agreements were that \$6 million GPR in the first half of calendar year 1998 and \$12 million in GPR in the current fiscal year would be appropriated to partially fund the HIRSP program. After application of GPR funding, full premium payments would be set to fund 60 percent of program costs and insurers and providers would each fund 20 percent of the remaining unfunded costs. The Department would track and fund financial performance of the plan against budget, and there would be a reconciliation process to balance out any variances from statutory funding shares. You transferred the program from OCI to the Department of Health and Family Services, and asked



DHFS to take care of these tasks.

The new funding arrangements translated into an immediate 15 percent rate cut for the people in the plan. HIRSP rates dropped from 192 percent of a standard risk rate to 150 percent. For many individuals aged 60 or more who make up the largest age group in the plan this meant close to \$1,000 in savings on an annual basis.

In the current fiscal year, we were able to keep premiums at 150 percent of a standard risk rate. I'm confident they will remain at 150 percent in the next fiscal year. A rate increase will still be needed, but only to reflect the marketplace increase in the standard risk rate. This means the new funding arrangements are working well for the people in the program who themselves pay the largest share of program costs.

There have been a number of problems in the administration of the HIRSP program since it was transferred to DHFS, particularly with the Department's inability until very recently to provide data on financial operation of the plan against budget, or to provide information on plan enrollments and demographics. I don't want to dwell on these problems, because I believe that some of the most serious problems are close to being fixed.

I raise the subject only because, when you transferred the program to DHFS, you reduced the ability of the HIRSP Board of Governors to effectively oversee the operations of HIRSP and approve policy changes in the program. I believe that if you had kept the HIRSP Board the same strong Board it was for nearly 18 years when the plan was administered at OCI, some of the problems we have had with the plan over the past 15 months might not have happened, and those that couldn't have been avoided might have been paid attention to and fixed earlier.

This said, I have three recommendations for changes to the HIRSP statutes in the current budget bill.

1. My first recommendation is that you make the Board a stronger Board again.

HIRSP is a partnership between the private sector, and the government. In this partnership, the people enrolled in the plan and the insurers and providers who share in plan costs pay the greatest share of the costs of the HIRSP program. They deserve a stronger voice in how their funding of the program under the statutes is accounted for and reconciled.

I think I do not have to tell you that the Department wishes the Board to speak in a very small voice and only as an advisory body. I think if the Board is to be limited to a strictly advisory role, you might as well not have a Board at all.

The Board has historically played a strong role in representing the interests of the people who are enrolled in the plan. To the extent that you have a weak board, it is these people who lose the most in terms of *not* having a voice in the operations of the plan.

- A. Feeling as I do, I would recommend that you delete those sections in the budget bill, as originally introduced, that would further weaken the Board.

- B. Next, I would recommend that the Board needs a stronger voice in at least six areas.

- (1) Development and approval of the HIRSP budget.

- (2) Oversight of financial management of the plan against budget.
- (3) Oversight of changes in HIRSP policy, including proposed changes in HIRSP benefits and other changes to statutes.
- (4) Reporting of data in HIRSP monthly reports, and other information of interest to the Board.
- (5) Assignment of work and scheduling of meetings of Board committees and sub-committees.
- (6) Development and release of reports specified in statutes as reports by the Board to the Legislature and to the Governor.

C. Finally, representation on the Board needs to be adjusted in two areas:

- (1) The Secretary of DHFS chairs the Board. Statutes should specify that no appointed member of the Board should be an employee of DHFS.
- (2) Statutes should specify that at least one of the consumer representatives on the Board must be a participant in HIRSP.

Planning documents relating to HIRSP are starting to talk about turning HIRSP into a "Medicaid look-alike program," but HIRSP is an insurance program, not a categorical benefits program. As the Department has learned, it is a very different program from Medicaid. I think you should want to keep it that way.

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The Secretary reviewed the most recent outlines of his legislative proposal at a meeting of the HIRSP Board yesterday.

At that meeting, the HIRSP Board agreed that new legislative language requested by the Secretary to give the Department greater flexibility in managing and reconciling financial performance of the plan is needed and should be drafted.

The proposed new language, as I understand it, would allow the Department to determine variances in the statutory 60%/20%/20% funding of program costs compared to actual funding on a calendar year basis, and make adjustments to reconcile those variances in the immediately following fiscal year.

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But the Board asked to be provided with more information relating to reductions in benefits, which some members of the Board would oppose.

3. Finally, I do think that I can speak for the Board in asking that you consider restoring the \$2,000,000 in GPR funding for HIRSP that was cut in the budget.
  - A. If these funds were restored, the appropriation under s. 20.435 (4) (af) would increase from \$9,900,000 to \$11,900,000 in each of the next two fiscal years.

Thank you for your time and patience.

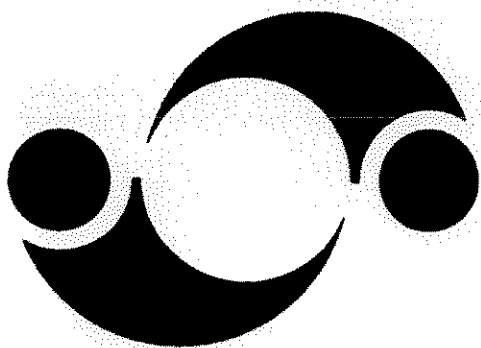
I would be pleased to try to answer any questions you may have.

1999 - 2001  
LEGISLATIVE INITIATIVES



Wisconsin Council for the Deaf and Hard of Hearing

Alex Slappey  
Chairperson



**WISCONSIN COUNCIL FOR THE DEAF & HARD OF HEARING**

2917 International Lane, 3rd Floor

P.O. Box 7852

Madison WI 53707-7852

(608) 243-5626 TTY/Voice

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### **MESSAGE FROM THE CHAIRPERSON ..... Alex Slappey**

The Wisconsin Council for the Deaf and Hard of Hearing is comprised of nine members, appointed by the Governor. As part of its purpose, the Council serves to provide advice and consultation to the Office for the Deaf and Hard of Hearing, the Division of Supportive Living, governmental bodies, private groups and individuals. The activities of the Council are driven by the desire to support people who are deaf, deafblind or hard of hearing in their efforts to achieve an equal place in their mainstream communities.

The *1999-2001 Legislative Initiatives* of the Council support the prudent allocation of public funds to enhance the contributions made by individuals and families in their support of people who are deaf, deafblind or hard of hearing. In addition, the Council's initiatives support the provision of comparable accommodation services that are critical to accessing essential basic services that are accessed by the general public.

If questions arise, please contact a Council member listed in the back of this document.

  
 Alex Slappey  
 Chairperson

## **WISCONSIN COUNCIL FOR THE DEAF & HARD OF HEARING**

### **POLICY RECOMMENDATIONS**

#### **STATUTE TO ESTABLISH BASIC CREDENTIAL REQUIREMENTS FOR SIGN LANGUAGE INTERPRETERS**

Many people arranging interpreting services are unaware of the skill levels required to provide safe and effective communication. Approximately 500,000 Wisconsin citizens are deaf, deafblind and hard of hearing, resulting in a high demand for interpreting services. The consequences of utilizing unqualified interpreters can be physically dangerous, if not fatal, in medical situations. In legal situations, people can, and have been, denied basic civil rights.

A statute is needed to establish guidelines for the basic skill and quality levels required of Sign Language Interpreters to interpret in a variety of settings. Proposed statutory language includes guidelines for the skill levels required to interpret in legal, mental health and emergency medical settings. Guidelines are also included for skill levels required to interpret in all other settings. Educational interpreters will be exempted from the statutory requirements. In addition, there are administrative sanctions for Sign Language Interpreters providing interpreting services in settings for which they are not qualified, including a fine structure and an appeal process.

#### **COUNCIL RECOMMENDATION**

- Support implementation of statutory guidelines to specify basic credential requirements for Sign Language Interpreters

## WISCONSIN COUNCIL FOR THE DEAF & HARD OF HEARING

### FISCAL RECOMMENDATIONS

#### **SERVICE FUND FOR THE DEAF, DEAFBLIND AND HARD OF HEARING**

The Service Fund for people who are deaf, deafblind or hard of hearing provides funding for sign language interpreters, realtime captioning and other comparable accommodations. Providing people with the means of presenting and receiving accurate information prevents exposure to life-threatening situations or situations where civil rights are denied.

- Funds support activities not covered by ADA, including support groups for battered women, substance abuse prevention, and cancer victims
- Funds support agencies in the process of obtaining funds for legal, mental health, and emergency medical activities
- In 1996, GPR funding to the Wisconsin Office for the Deaf and Hard of Hearing for the Service Fund was reduced from \$113,000 to \$50,000
- Funds are available to over 500,000 deaf, deafblind and hard of hearing Wisconsin citizens
- Demand for funds exceeds the \$50,000 allocation.

In SFY 98, \$50,000 purchased nearly 1,563 hours of interpreting services, providing services to an estimated 250 people. Service requests exceeding the \$50,000 allocation amounted to an estimated 752 hours or nearly 120 participants.

#### **COUNCIL RECOMMENDATION**

- Increase GPR funding to \$138,000 over the biennium from the current base of \$50,000



## COMMUNITY SERVICE ASSOCIATES

Community Service Associates (CSAs) provide:

- comparable accommodations in the form of interpreting services for deaf or hard of hearing Regional Coordinators of Deaf and Hard of Hearing Services
- information, assistance, education, and prevention services for deaf, hard of hearing and deafblind citizens

Funding for CSAs is supported by GPR and a combination of state/federal funds from the Division of Vocational Rehabilitation. In SFY 98, DVR funding support was reduced from \$72,620 to \$16,500. Efforts to compensate for the funding reduction included:

- reducing total CSA hours by over 900 hours per year
- providing interpreting services outside of normal job duties

Each of these actions reduced direct services provided to Regional Coordinators of Deaf and Hard of Hearing Services and to the deaf, deafblind and hard of hearing communities.

## COUNCIL RECOMMENDATIONS

- Fully fund the services of the Community Service Associates
- Increase the base \$110,500 GPR funding by \$83,779 in SFY 00 and \$89,607 on SFY 01

## FISCAL RECOMMENDATIONS

**Services to the Deaf and Hard of Hearing Fund:** Increase GPR funding to \$138,000 over the biennium from the current base of \$50,000.

**Community Service Associates:** Increase the base \$110,000 GPR funding by \$83,779 in SFY 00 and \$89,607 in SFY 01.

## POLICY RECOMMENDATIONS SUMMARY

**Statute to Establish Basic Credential Requirements for Sign Language Interpreters:** Support the implementation of statutory guidelines to identify basic skill and quality levels required of Sign Language Interpreters in an effort to ensure that people who are deaf, deafblind, or hard of hearing have access to safe and effective communication.

**GOVERNOR-APPOINTED MEMBERS OF THE WISCONSIN COUNCIL  
FOR THE DEAF AND HARD OF HEARING**

Chairperson: Alex Slappey  
(414) 728-7120 TTY/Voice  
Delavan

Vice-Chairperson: Sarah Benton  
(414) 728-7120 TTY/Voice  
New Berlin

Members: John Boyer  
(608) 257-5917 Voice  
Madison

Linda Jennison  
(414) 248-1234 V/TTY  
Lake Geneva

Eve Dicker Eiseman  
(414) 790-1040 Voice  
Mequon

Helen Rizzi  
(715) 834-2797 TTY  
Eau Claire

Margaret Ferris  
(414) 722-0436 Voice/TTY  
Neenah

Deborah Stamm  
(414) 544-9559 Voice  
Pewaukee

Mike Ginter  
(608) 833-3201 TTY  
Mt. Horeb

**NOTES**

722 Williamson Street  
P.O. Box 7851  
Madison, WI 53707-7851

State of Wisconsin  
**WCDD**  
**Council on Developmental Disabilities**

VOICE (608) 266-7826  
TDD (608) 266-6660  
FAX (608) 267-3906

Date: March 5, 1998

To: Representative Scott Jensen, Co-Chairperson  
Senator Brian Burke, Co-Chairperson, and Members  
Joint Committee on Finance

From: Judith A. Fell *JAF* Chairperson  
Jennifer Ondrejka, Executive Director

Re: Budget Adjustment Bill (AB 768/SB 436)

Thank you for your consideration of the following testimony on the Budget Adjustment Bill. The Wisconsin Council on Developmental Disabilities strongly supports some of the initiatives included in the Budget Adjustment Bill, however, the Council also strongly supports amending the Bill to assist parents on Supplemental Security Income with dependent children.

Following are the positions of the Wisconsin Council on Developmental Disabilities on specific budget items:

**Community Options Program (COP):** The Council has testified numerous times before the Joint Finance Committee on the importance of the Community Options Program to people with disabilities, and the critical need to address the waiting lists for services. The Council is very pleased with Governor Thompson's proposal to increase funding to COP by \$4.0 million GPR and \$2.4 million federal in 1998-99. The Council also strongly supports the projected transfer of \$6.0 million GPR from the Medical Assistance appropriation to COP. COP assists individuals to remain in their own homes, rather than entering nursing homes and other institutions; therefore, it is entirely appropriate to use savings in the MA nursing home budget to provide COP services.

**Family Care Program:** The Council supports many of the concepts of the Family Care Program included in the Budget Adjustment Bill, although it will not take a formal position on the Program until the Department of Health and Family Services has completed the detailed plan of the new long-term care system. The Council has voted to support the position paper *Building Upon What Works: Objectives for Long Term Care Redesign*, which was developed by a coalition of counties, and aging and disability organizations (copy attached). The concepts of proposed by Governor Thompson are similar to many of the principles in the *Building Upon What Works* paper. The Council strongly encourages Joint Finance to also support the recommendations in *Building Upon What Works* and the concepts underlying the Family Care Program.

**Pilot Projects to Extend Benefits to Working Individuals on Supplemental Security Income:** The Council strongly supports requesting waivers from the federal government to allow individuals with disabilities entering the work force to continue to receive critical comprehensive

Representative Scott Jensen, Co-Chairperson  
Senator Brian Burke, Co-Chairperson  
Joint Committee on Finance  
March 5, 1998  
Page 2

medical coverage. Many people with disabilities are eager to join the work force, however, they are prevented from working because of the need for Medicaid or Medicare coverage. The pilot projects will provide valuable information on the comparison of the actual costs to extend support to working individuals, and the benefits gained in taxes as people are able to work. The Council anticipates the pilot projects will demonstrate the overall gains to society of allowing individuals with disabilities to become taxpayers, and supports extending the pilot projects to a statewide basis at the earliest opportunity.

Medical coverage is a major disincentive to employment for people with disabilities, however, other barriers to employment also exist. The Council supports a position paper written by a coalition of disability organizations on *SSI/SSDI Work Incentives Reform*. The paper lists several steps to reduce and eliminate disincentives to work for individuals with disabilities (attached.) The Council also believes the Joint Finance Committee needs to reconsider the funding situation of the Division of Vocational Rehabilitation, which was created to assist individuals with disabilities to become employed.

**Division of Vocational Rehabilitation (DVR) Case Services:** The Council is concerned that DVR may be facing a shortage of \$500,000 GPR in FY 99 to provide case services to individuals with disabilities. The Council questions whether third-party matching can provide the level of choice, flexibility, and quality of services to consumers with disabilities needed to meet the requirements of the Rehabilitation Act. Third-party match is allowed under the Rehabilitation Act to provide innovative services; it is not necessarily meant to provide basic case services to individuals. The Council requests the Joint Finance Committee to carefully review the use of third-party matching and consider providing GPR to maintain case services in FY 99.

**SSI Interim Assistance:** The Council supports the Department of Workforce Development recouping a portion of the W-2 grant when a parent receives retroactive federal SSI benefits. But the amount recouped should not leave the parent with less income than they would have received if they had been originally eligible for the new C-Supplement program. The Governor's proposal provides families with the lesser amount. A fairer formula would provide families with the higher amount. The difference is significant to families trying to live on limited incomes.

For example, a single parent with two children:

Governor's Proposal	Monthly Amount if the parent received a W-2 T grant	\$ 628
Formula that took into consideration the amount the family would have received if originally eligible for SSI	Monthly amount if the parent was receiving both SSI (federal and state supplement) and C-Supplement	$\$577 + 154 = \$ 731$

Representative Scott Jensen, Co-Chairperson  
Senator Brian Burke, Co-Chairperson  
Joint Committee on Finance  
March 5, 1998  
Page 3

**SSI Parents with Dependent Children:** The Council strongly endorses the restoration of the AFDC benefit amount to SSI recipients. Although restoration is not currently in the Budget Adjustment Bill, the Council believes that the Adjustment Bill is the appropriate place to repair a program that significantly reduced the income in families headed by a parent with a disability. To become eligible for SSI, the parents had to prove their inability to hold a regular job. That is why they are receiving SSI. They are unable to bring in extra money to supplement their incomes. The new C-Supp program has placed families at high risk for homelessness and family breakdown. Attached to this testimony are some of the many written comments the Council has received from families who are receiving the new C-Supp payment.

Thank you for your consideration of this testimony. Please contact Jennifer Ondrejka, Executive Director, with questions or concerns at (608) 266-7826.

## SSI/SSDI WORK INCENTIVES REFORM

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### **Issue:**

For over 25 years consumers, advocates and rehabilitation providers have tried various approaches to reducing disincentives which prevent SSI and SSDI recipients from returning to work. The General Accounting office reports: "fewer than 1 percent of SSDI beneficiaries and few SSI beneficiaries leave the rolls to return to work each year". The loss of SSA health care coverage is a major disincentive to employment for persons with disabilities receiving SSI and SSDI.

### **Background:**

The National Council on Disability and disability advocates have worked with Federal legislators to draft bills which would address the SSI/SSDI work disincentives. Senator Jeffords of Vermont has drafted the Work Incentive Improvement Act of 1997. The bill incorporates several provisions that would address the problems of losing cash benefits and health care coverage due to substantial gainful employment (SGA).

### **Organizations:**

ARC - Milwaukee  
The ARC-Wisconsin  
Brain Injury Association of Wisconsin  
Client Assistance Program  
**IndependenceFirst**  
National Multiple Sclerosis Society - WI Chapter  
Older Adult Service Provider's Consortium  
Options for Independent Living, Inc.  
**Rehabilitation For Wisconsin, Inc.**  
State Independent Living Council  
**State Rehabilitation Planning & Advisory Council**  
United Cerebral Palsy of Southeastern Wisconsin  
United Cerebral Palsy of Wisconsin  
Wisconsin Coalition for Advocacy  
**Wisconsin Coalition of Independent Living Centers**  
Wisconsin Council on Developmental Disabilities  
Wisconsin Rehabilitation Association

### **Position:**

*We support efforts to develop an integrated and comprehensive strategy to reform Social Security law and regulations to support recipients in maximizing their work potential. We support the following reforms:*

- Access to medical coverage while working by expanding Medicare & Medicaid eligibility, extending premium-free Medicare coverage, scaling Medicare buy-in premiums to earnings, and creating a Medicaid buy-in option.
- Immediate return to an SSI/DI cash subsidy and health care benefit status because of a specific and verifiable need to leave the workforce related to medically determinable physical or mental impairments which prevent the individual from continuing their present level of work.
- An earned income SGA exclusion of \$500 indexed to inflation for both SSI and SSDI recipients. Changing SSDI to allow a sliding scale of benefit reduction similar to provisions for SSI beneficiaries.
- An expanded Impairment Related Work Expense (IRWE) tax credit to cover the extraordinary work expenses related to disability including those items necessary for preparation for and traveling to and from work, for current and former SSI/SSDI recipients.
- Equitably align SSI and SSDI return to work incentives.
- Reengineering of SSI/SSDI benefits programs and testing of varied strategies for return to work efforts. Wisconsin should be one of the five states to pilot the proposed SSI/SSDI reengineered benefits program.
- The establishment of work incentive counseling and assistance programs staffed by experts in entitlement and benefits who are familiar with rehabilitation, independent living and social services. These services should be funded by the SSA.
- Testing of options to current VR system such as vouchers and improved outcome-based payment systems.
- Early referral for rehabilitation interventions - before the individual is found eligible for benefits.
- Offering tax credits to employers for hiring and retaining beneficiaries

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P.O. Box 7851  
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State of Wisconsin  
**WCDD**  
**Council on Developmental Disabilities**

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FAX (608) 267-3906

## **Selected Comments From the SSI Parent Survey February, 1998**

(Comments are not edited, but quoted exactly as submitted)

As of February 1998 over 1,950 individuals have responded to the WCDD SSI Parent Survey. Many of the respondents have written comments on the survey. The following quotes are representative of the comments received by the WCDD. The full text of comments will be available at a later date.

### **ASHLAND**

- *"Because of the loss of income from AFDC, I am forced to sell our home. We may end up back in public housing. Sometimes those neighborhoods are not very good places to raise children."*

(A single mom who has a chronic illness and a mental disorder raising one child, aged 12)

### **BARRON**

- *"I want to know who figured out the math that has suddenly taken us so far below the poverty level. We already struggle for everything and now we must add worry to the struggle. It seems horrible to me in our "wonderful America" that those who need help and care the most are always ignored and misunderstood the most. I did not choose to be afflicted and my family should not be punished because I am. Thank you."*

(A single mom who has a chronic illness and a mental disorder raising two children, ages 16 & 18)

### **BROWN**

- *"Your letter asks for comments on the impact of losing AFDC for my children and instead getting an increase in SSI of \$77 per month per child. How can this be? Who figured out that a disabled parent can raise a child on \$77 per month. That is less than it would cost to place my children in foster homes and it is assumed that the foster home has at least one working parent. I would be glad to work, even at a minimum wage job. I apply repeatedly for work programs but no one will give a woman in a wheelchair who can not breathe with out oxygen, and had frequent bouts of difficulty breathing with oxygen, a chance."*

*My daughters are 12 and 14 years. I am fortunate to have the experience of parenthood when I have been ill all of my life. I have been divorced since they were preschoolers. Their father has evaded the law and pays no support. What can \$77 a month buy for a teen? Even if I could obtain food for a family of three on the \$144 food stamps I can receive, food stamps can not buy: tooth paste, shampoo, toilet paper, dental floss, or sanitary napkins, shoe laces school supplies, haircuts, bus fare, laundry soap, washer and dryer money etc. Clothes, even bought at thrift stores cost at least \$15 a month per child. You can not buy underwear, socks, stockings at thrift stores.*

*Two dollars and fifty three cents a day per child, \$77 a month. That would hardly pay for lunch eaten at school each day. Fortunately there is free school lunch but that may be cut next. Do we have cable TV? No. Nintendo, Sega, Playstation? No. Do we eat out or see a movie? Not often. What about birthdays and Christmas, or don't children with a disabled parent need gifts? I am discouraged. AFDC still left me below the poverty level but I could scrimp by. \$77 dollars a month per child just doesn't make it.*

*Brown County is a generous place. There are food pantries and thrift shops and caring people. I am sure it is worse for people in big cities or where rents are high. The idea behind W2 was to put able bodied people to work. I would love to have an able body and work. Even disabled I have done volunteer work when well enough. If there was another working parent there would be an income. I can not be the only single mother with no other source of income and no ability to work. It is the children who are punished. If AFDC can disappear how long with the \$77 continue, how long food stamps? I read the economy is booming, inflation low, interest rates low and jobs available. This is for able bodied persons only.*

*I would be happy to write letters to advocate for the needs of others like myself. I have already written many individuals in government. I would be happy to be interviewed."*  
(A single mom who has a life threatening chronic illness raising two children, ages 12 and 14)

- *"1 week before Christmas I received a letter saying in Jan. We would not be getting an AFDC grant at all. With my 82 in SSI and 434 in social security, I can't pay my rent, and we are being evicted and need to be out by March 5th. The depression has gotten worse, I'm tired of trying anymore & wish I were dead. My children hate me because we have to move. I also bought NO Christmas gifts for them."*  
(A single mom who has a physical disability raising two children, ages 15 and 17)

## **BURNETT**

- *"I was raped. SSI is my only means of support. In giving my child life, I risk my own! How could I give my child up for adoption. A non-disabled women would do the same! It's not fair to have such a low income to raise my child! Being disabled, on SSI, & raped is not my fault!"*  
(A single mom with a physical disability raising one child, aged 6 months)



## COLUMBIA

- *"I am returning my completed survey sheet pertaining to the recent changes made by the State of Wisconsin to the AFDC grant program. I am interested in telling my story, but I'm not sure how much longer I can afford telephone service. I thought I would include some additional information in this letter on how the changes to the AFDC program have affected my family.*

*I am a 32 year old divorced female with two young daughters, ages 5 and 9. I have a genetic disease referred to as Ushers Syndrome, a combination of Retinitis Pigmentosa (vision loss) and hearing loss. My hearing loss has also affected my speech. In past attempts at employment, my hearing loss and the resulting effect on my speech have provided the greatest obstacles, although my eyesight continues to deteriorate slowly. I am not currently employed.*

*Prior to January 1998, I was receiving the following monthly assistance;*

SSI/Soc. Sec. Disability	-	\$573.78
AFDC	-	426.00
Disregard Check	-	50.00
Food Stamps	-	70.00

*The AFDC agency in Marathon County had been collecting and retaining 25 percent of my ex-husband's salary, while sending me AFDC Assistance (\$426) and a Disregard Check (\$50) each month. Starting in January 1998, both the AFDC Assistance and Disregard Check have been dropped. To help compensate for the loss of the AFDC support, my SSI assistance has been increased by \$154 (\$77 per child). This leaves me \$322 short, which is supposed to be made up by child support payments which Marathon County will continue to collect from my ex-husband and forward directly to me. Unfortunately, he has difficulty retaining full-time employment and has never had anything but minimum wage work. His best month ever still feel about \$75 short of what I was getting from the AFDC program. His most current monthly support payments totaled only \$66 for the month of December 1997. Just before Christmas, he lost that job; so I have no idea on what, if anything, I will be receiving from him for January and beyond.*

*With the loss in monthly assistance, and very uncertain child support from my ex-husband, I am extremely concerned about providing proper food and clothing for my two children. I already take advantage of lower priced generic food brands and make good use of Goodwill outlets and garage sales. We do not subscribe to Cable TV, and we will soon have to avoid any form of child recreation that involves a fee. I also expect that my ex-husband's inability to provide adequate child support will force me to give up my phone service before long. This is a concern to me as far as emergencies that may occur when my children are in school or visiting their father, or even when they are at home. I have applied for rent assistance, but have not been given much hope of that being approved any time soon.*

*I think the State of Wisconsin probably had good intentions on their actions to reform welfare in Wisconsin. Based on the conversations I have had with confused personnel in support agencies in Marathon and Columbia Counties, it was apparently released too fast for proper*

*instructions and possible problems to be adequately addressed. I don't feel that it was intended to punish those of us with disabilities, but find my family in that position. I sincerely thank the Wisconsin Council on Developmental Disabilities for pursuing this matter on our behalf."*

(A single mom who has a hearing and vision impairment raising two children, ages 5 and 9)

## DANE

- *"I need to know if state, city, county, and federal are caring about their citizen poor people. Disabled parent like me can not work. No income or insurance to support my children or these children. Are you on my shoe? Do you understand my life? \$77 to raise a child in a month is nothing - can you personally live with \$77 in a month? Think about!!!"*

(A single mom with heart failure raising two children at home, ages 14 and 16)

- *"I am a single parent diagnosed with this disease which makes me disabled. I have not gotten one penny from the children's father. They cut my cash payment of AFDC-money \$362 per month for 2 teenage boys. They cut our food stamps and now becuz I'm working part-time they've cut my MA-which I have to have - my boys get \$40 a month from Social Security Insurance from my SS-disability-I am so upset & stressed out I don't how we will survive!"*

(A single mom who has a mental disorder raising two children, ages 6 and 10)

- *"Surely we are among the people most hurt by these changes. Budgets should not be balanced on the backs of poor families already in pain."*

(A single mom who has AIDS raising one child, aged 16)

- *"AFDC was terminated at the worst possible time, and it couldn't be no worse than a disabled parent trying to take care of their children and pay bills with this amount. If there was a wish I wish they can change the law that was passed. Especially for the amount for disabled parents."*

(A single mom who has a chronic illness raising one child, aged 4)

## FOND DU LAC

- *"I have No idea of How I am going to support my son on the very little bit of substanance I am allowed for a child. All I know is it CANNOT be done."*

(A single mom who has a chronic illness and a mental disorder raising two children, ages 15 and 16. One son receives SSI)

## GREEN

- *"They say that were're supposed to get child support but my ex doesn't pay. He isn't in jail he is on the run. My support worker told me to get a job so I did then she told me to work more hours, knowing that I would in turn lose SSI. I didn't ask to be put in this wheel chair! But being the way I am I will never be able to get ahead due to the system. I would really like to talk to some one about this I have a lot to say."*

(A single mom who has a physical disability raising one child, aged 6)

## JACKSON

- *"For that \$77.00 I get to raise my son isn't very much to cloth-him & feed him & school to. It sure costs me a lot more than \$77.00 for all of that. I don't think it is right for them to cut me off like that."*

(A single mom who has a physical and cognitive disability raising one child, aged 6)

## KENOSHA

- *"It is very stressful and impossible to support and live on the new amount of the grant we receive monthly."*

(A single mom who has a physical disability raising two children, aged 11 and 16)

- *"It really stinks. I ran out of food 3 days before my stamps came. They even cut my stamps. 2 growing children eat a lot. Or if they ask or need something you have to tell them sorry mom broke. IT SUCKS."*

(A single mom who has a physical disability raising two children, ages 11 and 14)

- *"I'm really hoping this letter will get passed to the legislature & governor. My name is ... & not only am I speaking for myself but for other people with disabilities and or handicap who can not work."*

*Here is my story- I was dignoised with M.S. & Seizure disorder in 1993. I was working full time in a nursing home as a Nursing Asst. (for 5 years) and also going to school part time for Operating Room Asst. I started having 2 to 3 seizures a week. Reason unknown at the time. Until one time I had one so bad I hit my head and was knocked out. That's when they found out I had M.S. to. I was so devested but I still tried to work. Until the M.S. started to take control of me and put a stop on my hopes & dreams in life. I take medication to control this problem but it doesn't stop it. I'm 30 yrs old and my life is worthless it seems like! I have 2 children who are very well taken care of - but hard at times.*

*I receive SSI now but it's not enough to live on. I'm a single mother, child support when the father pays it! How can a person live on what the state or so called government pays? (And when the father pays child support it goes to the state anyway!). I can see if you are very much able to work. You shouldn't get any help from the state, but what about us who can't. You still take it from us and only give enough to pay what Rent? What about food & clothes for your children!*

*Why are you taking from people who need this to live on. It's not our fault we ended up like this. Take it from people who don't need it and can work.*

(A single mom who has a chronic illness raising two children, ages 3 and 6)

## LINCOLN

- *"I'm trying to make it on \$800 a month when my rent alone is 595.00. How am I supposed to pay other bills, clothing, necessities??"*

(A single mom who has a mental disorder raising three children, ages 4, 8 and 10)

## MILWAUKEE

- *"The money I am getting is'nt enough. My rent is 425.00. I cant afford to move no where else. And my girls need things like shoes, clothes, personel things and so do I. We have just enough to pay rent and bills. Then whats left some food, and a little bit of household things. Then its gone. They have no money for field trips at all."*

(A single mom who has a mental disorder raising two children at home, ages 11 and 12)

- *"It's hard to support my children and pay \$395.00 + 45.00 + 54.00 and I have a furniture bill. On only 644.00 a month. I can't work if it wasn't for my sister writing-n-helping me. I will be in a shelter or have my children taking which is the only reason why I'm living"*

(A single mom who has a mental disorder raising one child, aged 5)

- *"It's hard as is living with a illness it's even harder with kids because you have to worry about how you going to take care of them."*

(A single mom who has a physical/neurological disorder raising two children, ages 7 and 17)

- *"This reduction is a real hardship. I feel we are being punished for our disabilities. How am I supposed to make up this loss of money."*

(A single mom who has a mental disorder raising two children, ages 12 and 7)

- *"I) I thought the whole idea of WELFARE was to HELP those in need with dependent children.*

- 2) *I also thought the whole idea of WELFARE REFORM was to make those who COULD WORK, go to work!*
- 3) *Well, MOTHERS and or FATHERS on SSI or disability are in NEED of HELP FINANCIALLY to take GOOD CARE of their CHILDREN!*
- 4) *WE were already living WAY BELOW POVERTY LEVEL FOR SOMETHING WE HAVE NO CONTROL OVER!!!"*

(A single mom who has a physical and mental disability raising one child, aged 1)

- *"The situation w/AFDC puts those of us on SSI (w/children) in a Catch 22. The grant is so much lower than AFDC, that the only way to pay our bills is to work. But being on disability, we can't work. How is this fair to our children? We should go without because we're disabled?"*

(A single mom who has a mental disability raising two children, ages 5 and 10 months)

## MONROE

- *"I think it is unfair for the handicapped to be cut. If the parent can not work because of medical reasons, I feel that they shouldn't have to suffer more then they already are."*

(A single mom who has a physical/neurological disability raising two children, ages 14 and 16)

## OCONTO

- *"It's very hard to live on the Income I was receiving but without the AFDC money gone, Its even more Difficult to have a decent living. I won't knock the amount of money I get now but I would Love my AFDC money amount back. I can just cry, when I try to figure out how to pay of important things with no money. I hope there is a solution fast."*

(A single mom who has a mental disorder raising two children, ages 7 and 9)

## OUTAGAMIE

- *"Anything extra would be appreciated. I can't drive. I'm in a wheelchair. I have a seizure disorder which is pretty well controled with medication. I still have a small mortgage to pay off. My property taxes are about half of what I get each month, that's why its hard for us that can't work to get by on SSI alone. Believe me, I would rather work than be in my condition."*

(A single mom who has MS with 2 children at home raising two children, ages 17 and 18)

- *"I still have a 15 years old daughter live with me. With the W-2 program, she only receives \$77/month which cause us a very hard-ship. We both have an income of about \$600/month and we have to pay our rent, utilities, phone, transportation, food, and clothing. We try our very best to manage our budget, but with only \$600/m it's very hard. I wish my daughter gets \$250/month."*(A single mom who has a physical disability and chronic illness raising one child, aged 16)

## ROCK

- *"Since I was cut off of AFDC I don't have any money to buy my kids shoes or clothes. Also don't have enough money for household goods. I am struggling because I am legally blind and unable to work."*  
(A single mom who has a visual impairment raising 3 children, ages 5, 8, and 17)
- *"It is hard enough trying to make it on the SSI my husband & I receive. The 248.00 I got from AFDC before just helped us barely make ends meet. Now I'm not sure what to do. The house bills have to be paid. We have a home but even renting would cost me more. The Food Stamps help but they don't pay the bills. It is very upsetting to never know if & when you will be able to pay bills."*  
(A couple raising 1 child, aged 16. Both parents have physical disabilities)

## WAUKESHA

- *"Before W-2, I had all 3 children live with me because I had a higher income coming in. Now I have two and will be down to one soon because I can't participate in work requirements of W-2. Also my housing has suffered, I was evicted due to the income changes."*  
(A single mom who has a physical disability, chronic illness, and mental disorder raising three children, ages 2, 15 and 17)
- *"I feel it is wrong for the government to take away the basic amount that is needed to survive in this country today. More money would be needed if these children of loving homes were forced to be placed in 3<sup>rd</sup> parties care. Why should we be penalized for having a disability."*  
(A single mom who has a physical/neurological disability raising three children, ages 11, 12 and 13)

## WINNEBAGO

- *"I would like to say something profound or intellectual but I feel hopeless for my children and myself. So anger is what comes across. This situation is not one I chose. I am very concerned about my children. I am a 50 yr old disabled women with two small children to raise. We had to leave an abusive home life. With the new grant I feel I went from bad to worse. You can't raise a child on \$77.00 a month. I try to get on programs to help with rent etc. But one program does not compliment another. So instead of help you get cut in another way "like food stamps." So what you may save in rent you loose in food stamps."*  
(A single mom who has a physical disability and visual impairment raising 2 children, ages 7 and 10)

## WOOD

- *"The \$77 C-Supp amount isn't enough. Transportation costs are a lot - In Marshfield one must pay \$70 a quarter - just for the school bus ride to and from school each day. I don't drive - so I must pay this amount so my daughter get to school & back. In Marshfield NO Dentists wil accept medical. Assistance for Dental visits. I must pay these expenses on my*

*own. I am angry. I've been discriminated against at all levels in society thru-out my life. But my daughter is the one who deserves more. I have many expenses. I was struggling before. This only compounds the real-life issues and stressors."*

*(A single mom who has cerebral palsy raising one child, aged 13)*

- *"Since Dec. 1, 1997 when I was cut off of AFDC my son & I cannot survive on my SSI money alone. We cannot afford to buy healthy food - which I need because of my illness."*

*(A single mom who has an incurable blood disease raising one child , aged 1)*

- *"I can't explain the Hardship this has caused my son & I. There isn't enough money to pay the bills. Its very depressing to think I'll never own a home or a dependable car. Banks will not finance me because my income is so low. If only the government had to live on my income."*

*(A single mom who has a physical disability raising one child, age 11)*

- *"I would like to raise my child with a little dignity. I don't like being depressed. It's like, you take a step forward and two backwards. They just don't want you to succeed."*

*(A couple raising one child, aged 9. The mother has a physical disability and mental disorder. The father has a chronic illness and mental disorder)*

# BUILDING UPON WHAT WORKS: OBJECTIVES FOR LONG TERM CARE REDESIGN

February, 1998

ARC-Milwaukee  
ARC - Wisconsin  
Barnes AARP  
Board on Aging & Long Term Care  
Brain Injury Association of WI  
Center for the Deaf & Hard of Hearing  
Coalition of Wisconsin Aging Groups  
Coulee Region RSVP Advisory Council  
Dane County Commission on Aging  
Family Voices  
Fitchburg Commission on Aging  
Independence First  
Milwaukee Co. Commission on Aging  
National M.S. Society - WI Chapter  
Rehabilitation for Wisconsin  
SAGE/Milwaukee  
St. Ann Adult Day Care

State Independent Living Council  
So. Milwaukee Grobschmidt Sr. Center  
United Cerebral Palsy of WI  
Waushara Co. Commission on Aging  
Waushara Co. LTS Planning Committee  
Wisconsin AARP  
WI Assn. of Area Agencies on Aging  
WI Association of County & Tribal Aging  
Unit Directors  
WI Coalition for Advocacy  
WI Coalition of Independent Living  
Centers  
WI Council of Senior Citizens  
WI Council on Developmental  
Disabilities  
WI Council on Physical Disabilities  
WI Rehabilitation Association



## ***Introduction***

The organizations which support this position paper share many common views with the Department of Health & Family Services in regard to Long Term Care (LTC) Redesign. We agree that the need for reform is urgent, and we support the Department's guiding principles for redesign. The differences in implementation approaches which loomed so large in May, 1997 have diminished. Even though there are many important issues yet to be resolved, there is increasing optimism that a proposal reflecting a consensus of the Department and outside groups can be achieved.

The Department has also made positive changes in the format for the Redesign planning process. The recently-formed Consolidated Steering Committee provides an opportunity for all the key stakeholder perspectives (including consumer and family views) to be in the same room at once. The new work groups also enable Department staff and people outside the Department to dig into the key issues together. Over the next few months, we also hope that the views of current and prospective LTC recipients will figure more prominently in the process.

This document reflects the current views of our organizations on the direction we believe the process should go from here. This is not an ultimatum; rather it is an attempt to clearly communicate what we have heard from consumers and what we have learned from our combined experiences of working within the present LTC system. We intend to bring these views to the table in the various forums in which the redesign process will unfold in the coming months. All of our organizations have direct contact with LTC recipients, their families and other people waiting for service. These ongoing ties with so many "customers" give us an invaluable vantage point from which to participate in the redesign process.

The phrase "Building on What Works" carries a lot of meaning for us. Notwithstanding the flaws in the current LTC system, there are also many strengths which must be preserved: the positive values and practices associated with the Community Options Program, the individualized approach that many counties and providers utilize in service delivery, the state-county partnership, and the high caliber of many case managers and provider staff involved in long term care. Throughout the remainder of the redesign process, we encourage everyone involved to continually be on the lookout for ways to capitalize on, extrapolate from, and refine the best practices already happening in Wisconsin. Redesign is hard enough without reinventing the parts of the wheel that are not broken.

Timing is also emerging as an increasingly important issue in redesign. As each month goes by, more questions arise of "how long will this take?", and "do all the issues have

to be settled before a bill can be drafted?" We believe that a balance must be struck between getting closure on the major questions soon, while leaving other implementation issues to be addressed during and after the legislative process. Advance planning is important but some things will only be worked out through a "learn by doing" approach. We are pleased that Governor Thompson has laid out a timeline for the development of LTC Redesign legislation in 1998, and for implementation of the system by July, 2000. We also agree with the Governor's proposal to enable a small number of counties to pilot the redesign principles in actual LTC service delivery (in addition to the current single entry pilots).

Lastly, we support the current separate planning effort for children and families' LTC issues. It is not yet clear whether a system overhaul is needed for this population, and if it is, what form it should take. These are important questions and they must be worked through before any decisions are made.

### ***Key Objectives for Long Term Care Redesign***

Our organizations have identified a number of key objectives which collectively describe our aspirations for Long Term Care Redesign. These aspirations are organized under five headings, beginning with our understanding of what direction consumers are pointing towards for redesign.

### ***Consumer Priorities***

In past years (and in recent focus groups), consumers of long term care services and their families have emphasized a number of features which they consider essential to incorporate into the Long Term Care System of the future:

1. All current obstacles to people receiving LTC services in the most natural and least restrictive setting must be removed. In other words, for the first time in Wisconsin the money must really follow the person, wherever the person wants to go.
2. Consumers must have the maximum range of choices possible, including choices not previously available. This includes people currently residing in institutions. Every person must have the opportunity to develop his/her own plan, and choose the manner and location in which services will be delivered. Participant-directed services should also be an option for all persons receiving long term care. Consumers should have the prerogative of sharing or delegating the above choices to families or others.

3. Functional eligibility criteria for long term care must be developed based upon the characteristics and needs of individuals currently receiving long term care services in Wisconsin. Individuals currently receiving support and others who have needs similar to those individuals must continue to be eligible for services.
4. Once the new system is on line, all eligible persons should be able to access the system in a simple, straightforward and timely way. All persons who meet eligibility criteria must receive an assessment of their needs for support and be entitled to a flexibly defined set of comprehensive long term care benefits.
5. Most LTC consumers, as well as many families and friends, would welcome the opportunity to enter into a partnership with the LTC system, both to explore the most cost-effective uses of public funds and to reach an understanding regarding the balance of paid service vs. (voluntary) supports by families and friends. This will require flexibility and a genuine desire on the part of government to meet people halfway in such a partnership. It also requires the ongoing provision of timely, accurate information to consumers, families, and friends.
6. Individuals who receive LTC services and/or acute/primary health care services should no longer experience a disincentive to seeking or retaining part-time or full-time paid employment, nor should it be so difficult and complex for employed individuals to navigate through the LTC system. The overall thrust of the LTC system (as well as specific features related to financial eligibility, cost sharing, location of service provision, etc.) should be to reinforce and actively assist people in securing employment.

### ***Funding***

7. All long term care funding streams must be consolidated and simplified. However, funding for long term care must remain separate from funding for primary and acute health care.
8. Funding for people who meet the functional eligibility criteria will be provided according to levels of individual need. If people receiving services wish to move to a different setting or county, their funding must go with them.
9. Funding for single entry point functions, and emergency and protective services will be provided to each local LTC system through a specific allocation for those purposes.

10. Planning, budgeting and funding will be flexibly provided across calendar years. Funding not spent in a particular calendar year will be retained by local government for the express purpose of reducing waiting lists and improving LTC services.
11. Upon completion of the transition to a new system, it is expected that funding will be sufficient to meet the needs of all eligible persons. During the transition, the state must establish target dates by which all individuals will receive public funding, as well as criteria for prioritizing individuals to leave waiting lists. It is also essential that the state spell out what sort of "fiscal safety net" will be in place if a local LTC system "goes bankrupt".

### ***Systems Governance and Management***

12. From the perspective of consumers and advocates, there is no universal "right answer" to the question of "who should manage the LTC system?" For counties which want to take on the extra responsibility of managing the new expanded LTC system, there is the advantage of local control and consumer access to local decision-makers. If these counties can demonstrate their capacity to fulfill the performance requirements of the system, they should have the opportunity to try their hand at managing the system.

However, some counties have demonstrated more proficiency in long term care than others. Consumers and advocates will not assume that all counties will perform well in the new LTC environment. Consequently we strongly endorse the following safeguards:

- real state oversight to ensure that the guiding principles and quality outcomes of LTC are achieved in each county (as described in #14 below),
  - strong guarantees of consumer choice, including safeguards to address a county's tendency to favor its own county-operated services and traditional provider relationships,
  - an appeals process with real teeth, with access to state government at some stage of the process, and
  - access to an independent source of advocacy (as described in #17 below.)
13. A local long term care policy board should be formed in each county, with at least 51% of the board composed of elderly people, people with disabilities, and their family members. This board will be responsible for long term care program planning, oversight and policy making in each local LTC system. This

will be a true governing board, with a shared role (with the county) in the selection of key managers in the LTC system, safeguards to ensure that some appointees to the board come from local/regional aging and disability groups, and a clear delineation of which policy decisions fall within the board's province.

### ***Quality Assurance***

14. State specified and monitored performance criteria will be established for the provision and management of long term care services. In addition to health and safety requirements, local government will be required to meet specific performance and outcome requirements based upon the needs of the individuals being served. A range of state monitoring options will be developed, including the clear power to replace agencies which do not meet the requirements. As part of its monitoring activity, the state should review (and disseminate) the patterns of individual service outcomes in each locale.
15. While funding for long term care shall remain separate from funding of primary and acute health care, specific performance criteria will be established to require the local long term care agency and the local health care delivery system to coordinate the provision of acute and primary health care with long term care.
16. As a permanent feature of the new long term care system, the state should schedule periodic public forums around the state to receive input regarding how the system is working and to solicit recommendations on how to improve the system.

### ***Advocacy and Rights Protection***

17. An independent entity (or entities) with no conflict of interest (i.e. no direct service provision) must be designated and adequately funded to provide advocacy services to individuals within the long term care system. The independent entity should be consumer controlled and have the capacity to pursue all appropriate remedies.